

To: Vikki Wachino, Deputy Administrator, CMS, and Director, Center for Medicaid and CHIP Services

From: Rusty Stafne, Chairman, Fort Peck Tribes
Darrin Old Coyote, Chairman, Crow Tribe of Indians
Ken St. Marks, Chairman, Chippewa Cree Tribe
Beau Mitchell, Chairman, Rocky Boy Health Board
Kevin Howlett, Health Director, Confederated Kootenai and Salish Tribes
Rosemary Cree Medicine, Director, Blackfeet Tribal Health Department
L. Jace Killsback, Tribal Health Administrator, Northern Cheyenne Tribe
Velva Doore, Director, Fort Belknap Tribal Health Department
LeeAnn Bruised Head, Director, Missoula Urban Indian Health Center
Tressie White, Assistant Director, Helena Indian Alliance
Aaron Wernham, CEO, Montana Healthcare Foundation

Cc: Sylvia Matthews Burwell, Secretary, U.S. Department of Health and Human Services
Kristie Canegallo, Deputy White House Chief of Staff for Implementation
Jon Tester, U.S. Senator for Montana, ranking member, Senate Indian Affairs Committee
Steve Bullock, Governor of Montana

Date: October 15, 2015

Re: **Importance of Montana's proposed Medicaid expansion to American Indian Health**

Please accept this comment on the Montana Health and Economic Livelihood Partnership Program section 1115 demonstration waiver application. This memo is respectfully submitted by the tribal leaders listed above and the Montana Healthcare Foundation.

As CMS considers Montana's proposed Medicaid expansion and demonstration waiver, it is important to fully examine the importance to the health of the state's American Indian people.¹ Given the findings presented in this memo, the signatories support the expansion of Medicaid and the exemptions outlined for American Indian/Alaska Native residents as described in the Montana Department of Public Health and Human Service (DPHHS) 1115 waiver application submitted to CMS on September 15, 2015.

Concerns have been raised regarding the requirements for premiums and co-pays that would be required of Medicaid recipients, as set out in the state's waiver. Major findings of the analysis herein include:

- Montana has the largest American Indian population among the six states that have waivers in place to expand Medicaid, estimated at approximately 65,000 people.
- More than 20,000 American Indian people—nearly one third of the state's Medicaid expansion population—would gain eligibility for Medicaid under the state's proposed expansion.

¹ We acknowledge and appreciate the assistance of the Montana Budget and Policy Center in preparing this memo.

- *American Indians are exempt from cost sharing*, and hence nearly one third of the Montanans who would gain eligibility for Medicaid under the proposed expansion would be exempt from the state’s proposed cost sharing.
- Montana’s American Indian people experience severe health disparities, including a median age at death more than 20 years less than white Montanans, and markedly elevated rates of most important causes of mortality.
- Severely limited access to health care contributes to the health disparities documented among Montana’s American Indian people. Montana has the largest share of uninsured American Indians of any state in the U.S., at roughly 40 percent.

With the creation of the White House Council on Native American Affairs and the announcement of “Generation Indigenous,” the Obama Administration has expressed a deep commitment to addressing the complex challenges facing Native American communities. Montana’s proposed expansion of Medicaid represents an indispensable opportunity to address one of the most challenging inequities facing Indian Country: lack of access to comprehensive health care and its impact on health and quality of life.

American Indian population in Montana

Montana has the largest American Indian population among the six states that have waivers in place to expand Medicaid (see table 1). Montana is home to federally recognized tribes on seven reservations, one state recognized tribe, and a large urban American Indian population. In Montana, American Indians make up approximately 6.5 percent of the total population (approximately 65,000 individuals),³ the fifth largest of any state in the nation.⁴ Of these, an estimated 39,000 live on or near reservations, with the remaining 26,000 living off reservations, primarily in urban areas.⁵

Table 1 American Indian Population in states with waivers to expand Medicaid	
Montana	6.5%
Arkansas	1.0%
Michigan	0.7%
Iowa	0.5%
Indiana	0.4%
Pennsylvania	0.3%
Source: U.S. Census Bureau ²	

Access to health care

Eligible American Indians receive health care through the Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services. The Billings Area IHS is responsible for oversight of Tribal Health programs in Montana and Wyoming, including IHS-run clinics, tribally-administered programs, and Montana’s five urban Indian health centers.

The Indian Health Service is a primary health care provider for many American Indians in Montana. Since IHS clinics service eligible American Indians regardless of insurance status, many individuals do not purchase insurance through the health care exchanges. Out of 33

² “Indian Health Service,” *GAO Report to Congressional Addresses*, September 2013, <http://www.gao.gov/assets/660/657394.pdf>.

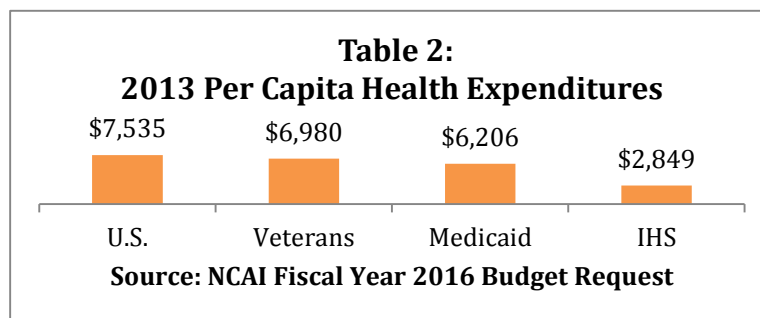
³ “ACS 3-year estimates,” *U.S. Census Bureau*, Selected characteristics of the total and native populations in Montana.

⁴ “American Indian & Alaska Native Populations,” *Centers for Disease Control and Prevention*, Updated February 3, 2015, <http://www.cdc.gov/minorityhealth/populations/REMP/aian.html>.

⁵ “Governor’s Office of Indian Affairs,” *Montana.gov*, <http://tribalnations.mt.gov>.

states with significant American Indian populations, Montana ranks the highest of any state in uninsured American Indians (40 percent).⁶

Unfortunately, eligibility for IHS services does not equate to adequate access to health care for every beneficiary. The IHS is funded at a lower per-capita rate than any other public insurance program (see table 2). With a budget that has been estimated to cover only 60 percent of the actual need, the IHS is able to provide only a limited range of basic and triage services in specific communities.⁷



This underfunding of health care services results in inadequate access to preventive care for many American Indians, and restricts access to referrals outside the IHS system for services not provided in IHS facilities. Shortages of qualified health care providers compound this problem for many of Montana's reservation-based American Indian communities. In urban areas, services are even less available.

The lack of health insurance has important repercussions for access to health care services. IHS and tribally-run facilities receive funding for two purposes – operating funds and contract services; urban clinics are not eligible for this funding. In urban areas, where contract-based funding is not available, some chronically ill individuals find themselves forced to return to reservations in hopes of being eligible for contract care. The operating funds are only intended to provide access to services that are not provided at the facility, and require a referral to an outside provider. The list of services not provided in Montana's IHS facilities depends on current staffing and spectrum of services offered in each facility, and includes most specialty consultation, diagnostic procedures and surgeries, as well as basic services such as prenatal care and delivery, colonoscopy, advanced imaging and others.

For any referral service, however, a patient must be approved based on eligibility requirements, on whether the particular service is considered a high-priority need, and finally, based on whether there are funds available. Given the limitations on IHS funding, these requirements often constitute a "life-or-limb" litmus test. Moreover, when the funds designated each year for purchased and referred care run out, patients are denied approval, and without insurance, must either forgo the care or pay out of pocket.⁸

In Montana, almost 70 percent of American Indians report that they rely on the IHS for health care. Given the under-funding of IHS services and shortages of providers, these individuals

⁶ Ed Fox, PhD, and Verne Boerner, MPH, "Health Care Coverage & Income of American Indians & Alaska Natives," October 2012, http://www.edfoxphd.com/Health_Care_Coverage___Income_of_AmeriCan_Indians___Alaska_Natives___Health_care_coverage_and_income_of_aians.pdf

⁷ "A National Roundtable on the Indian Health System and Medicaid Reform," *Urban Institute*, August 31, 2005, <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411236-A-National-Roundtable-on-the-Indian-Health-System-and-Medicaid-Reform.PDF>

⁸ Laura John, "Office of American Indian Health: A demonstration of a genuine state-tribal partnership," *Montana Budget and Policy Center Blog*, July 16, 2015, <http://www.montanabudget.org/category/blog/state-tribal-policy-blog/#sthash.EYRWsa0b.dpuf>

cannot be considered to have adequate access to health care should their needs extend beyond the basic clinical services offered in their IHS facility.⁹

For these reasons, other forms of coverage, such as Medicaid, make up an indispensable part of the medical safety net for both urban and reservation-based Native communities.

Consequences of limited access to health care: health disparities among Montana's American Indian people

American Indian people in Montana suffer from marked disparities in life expectancy and most measures of health and illness. The causes of health disparities are complex, yet inadequate access to health care is one well-documented, fundamentally important, and correctable contributor. For American Indians, the underfunding of IHS has been recognized as one important factor contributing to the health disparities documented throughout this population.

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While American Indian people around the U.S. experience substantial health disparities, those documented among Montana's American Indian people are particularly concerning. American Indians residing in Montana have lifespans nearly 20 years shorter than white Montana residents. The median age at death for an American Indian male is 56, compared with 75 for a white male in Montana, and the median age at death for an American Indian woman is 62, compared with 82 for a white woman.

The age-adjusted mortality rates for all leading causes of death are substantially higher among American Indians than among non-Native Montanans. For example, the mortality rate per 100,000 people for cardiovascular disease is 287 among American Indians, compared with 210 for non-Natives; for cancer, 216 compared with 167; for respiratory illnesses, 133 compared with 84; for vehicle injury, 48 compared with 20; and for all other injuries, 70 compared with 32.¹¹

Among American Indians in Montana, 23 percent rate their health as fair or poor, and 13 percent experience frequent poor mental health; by comparison, 14.5 percent of white Montanans rate their health as fair or poor, and 9.6 percent report frequent poor mental health. Nearly 25 percent of Montana's American Indian population reports having been diagnosed with diabetes or pre-diabetes, compared with 13.5 percent of white Montanans.¹²

⁹ Ed Fox, PhD, and Verne Boerner, MPH, "Health Care Coverage & Income of American Indians & Alaska Natives," October 2012, http://www.edfoxphd.com/Health_Care_Coverage___Income_of_American_Indians___Alaska_Natives___Health_care_coverage_and_income_of_ainians.pdf.

¹⁰ Donald Warne, MD, MPH, "Research and Educational Approaches to Reducing Health Disparities Among American Indians and Alaska Natives," *Journal of Transcultural Nursing* (July 2006), pp. 1-6.

¹¹ "The State of the State's Health," *DPHHS.MT.GOV*, June 30, 2013, V. 1, <http://dphhs.mt.gov/Portals/85/publichealth/Publications/State%20of%20the%20State's%20Health%20Final%209%20.2013.pdf>.

¹² "2013 Montana BRFSS Annual Report," *DPHHS.MT.GOV*, October 2014, <http://dphhs.mt.gov/Portals/85/publichealth/documents/BRFSS/Annual%20Reports/2013%20Annual/2013MTBRFSSAnnualReport.pdf>.

Projected changes in insurance status under Montana’s proposed expansion of Medicaid

If Montana’s Medicaid waiver application is approved, Montana will rank the highest in number of newly eligible American Indians compared to other waiver states (see table 3). An estimated 20,000 American Indians would gain eligibility for Medicaid under Montana’s expansion.

The Montana Health and Economic Livelihood Program creates a critically needed opportunity to improve access to health care coverage to thousands of American Indians residing in Montana.

Table 3 Percentage of total American Indian population newly eligible for Medicaid		
Pennsylvania	7%	3,005
Arkansas	13%	3,667
Michigan	16%	11,702
Indiana	17%	4,441
Iowa	17%	2,575
Montana	30%	20,403
Source: United States Government Accountability Office ¹³		

Montana’s expansion plan includes cost-sharing provisions for enrollees, including premium and co-pays for certain services, to be administered by a third party administrator.¹⁴ As detailed in the DPHHS waiver proposals, however, American Indian residents will be exempt from the newly created third-party administered plan under the HELP Act and will be enrolled in traditional Medicaid. This ensures American Indians are exempt from premium and cost sharing requirements and will be entitled to full benefits under the current Medicaid program. This exemption should not be overlooked. American Indians exempt from cost-sharing requirements make up approximately one-fourth to one-third of the population that would gain eligibility for Medicaid under Montana’s proposed expansion.¹⁵

Conclusion and recommendations

Limited access to health care among Montana’s American Indian people and its impact on health and quality of life is one of the most important challenges facing the state. As noted by Montana Governor Steve Bullock, “too many American Indian families are losing entire generations and experiencing the tragedy of burying both their elderly and their youth too early”, and “the current health care delivery system in Indian Country limits access to preventative care and quality health care services and providers.”¹⁶ Demonstrating Montana’s commitment to addressing this problem, the Governor recently signed an executive order establishing an office of American Indian Health and directing DPHHS to oversee and coordinate the development and implementation of a government-wide action plan.

Expanding Medicaid in Montana offers an extraordinary opportunity to take a substantial step toward eliminating health disparities among Montana’s American Indian people: we urge the Department of Health and Social Services to approve Montana’s 1115 and 1915(b) waivers. If

¹³ “Indian Health Service,” *GAO Report to Congressional Addresses*, September 2013, <http://www.gao.gov/assets/660/657394.pdf>.

¹⁴ Montana Department of Public Health and Human Services. “Montana Health and Economic Livelihood Partnership (HELP) Program: Section 1115 Research and Demonstration Waiver Application.” July 7, 2015. <http://dphhs.mt.gov/Portals/85/Documents/MedicaidExpansion/MontanaSection1115and1915b4Waivers.pdf>.

¹⁵ Ed Fox. “Health Care Reform: Tracking Tribal, Federal, and State Implementation.” Kauffman & Associate, Inc. May 20, 2011. See also, U.S. Government Accountability Office. “Indian Health Service: Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment.” September 2013. <http://www.gao.gov/assets/660/657394.pdf>.

¹⁶ Steve Bullock, “Executive Order Establishing a State Office of American Indian Health,” *State of Montana Office of the Governor*, June 16, 2015, https://governor.mt.gov/Portals/16/docs/2015EOs/EO_06_2015_Office_American_Indian_Health.pdf.

you would like any additional information, you may contact Dr. Aaron Wernham at aaron.wernham@mthcf.org. The Montana Healthcare Foundation would happily provide contacts for each of the tribal leaders who have submitted this letter as well, if helpful.